Section V: PROGRAM DEVELOPMENT RECOMMENDATIONS

The Needs Assessment describes two primary goals to be met within the Program Development category recommendations. "First, a floor of service capacity must be solidly established across all regions for the most basic set of community based services necessary to treat emotional disturbances and limit the utilization of more expensive, intensive services to those children for whom those intensive services are the best and necessary choice. Second, the system as a whole needs to expand the availability and quality of child mental health expertise in all regions." The parties have identified a third important goal of increasing access to community based mental health services. All three of these goals are addressed in this plan.

The Governor's proposed budget will begin to address the first goal identified in the Needs Assessment. Additional funding is needed to expand the base services across all regions. The action items below primarily address the two remaining goals of expanding the availability and quality of children's mental health expertise, and of increasing access to services.

The Governor's budget proposal for FY 2002 includes $4.2 million in state general funds with a resulting $1.7 million in federal matching funds for Medicaid reimbursed children's mental health services. This will increase the State's ability to purchase services for children with SED. In addition, the Governor has proposed funding for 15 new positions within the Department of Health and Welfare, 14 of whom will conduct mental health assessments for children whose parents are requesting services or those referred by other agencies. This new funding is necessary to increase access to services. Requests will be made for an additional 10 positions in the next fiscal year, as represented in the current budget proposal. Additional funding recommendations will be made by the ICCMH as described in recommendation 23.

The Needs Assessment noted "The authors believe that the service capacity model recommendations in Appendix C should be viewed as long-term goals for system capacity development—near term goals should be set to build more realistically on existing capacities. A statewide planning process should be implemented which enables communities and regions to better identify current capacities and to set those realistic near-term goals."

The formation of the state and local councils, and the action items below create a statewide planning process envisioned in the Needs Assessment to better identify current capacities and to set realistic near-term goals for program development. As the councils and DHW develop common service definitions and baseline information about current capacity, the feasibility and desirability of reaching the long term service capacity goals identified in the Needs Assessment will be re-evaluated and confirmed or adjusted, consistent with findings, needs and best practice.

FINANCING STATEMENT:

Recommendations 25-41 address the core services that the Needs Assessment recommends as the focus of capacity expansion throughout the state. The six core services are funded in one of three ways: 1) general funding; or 2) Medicaid or other federal funding sources; or 3) a combination of general funds and federal funds. Additionally, there are recommendations that may be accomplished within "existing resources." These are resources that are already in place, such as existing staff, reoccurring funding sources and, in some cases, federal grants. The type of funding depends on the particular services, as well as the eligibility requirements. DHW already has existing general funds which are equally divided among the regions, resulting in $414,285 distributed to each region for the provision of children's mental health services. If the Governor's current budget request is granted, there would be additional new funding of approximately $3 million for the expansion of the core services outlined in this category. Below each core service is outlined with the potential funding sources identified:

Number 26: Crisis Response. Much of this would be accomplished within existing resources. It requires a great deal of staff time in developing the protocols. Staff and contractors may be utilized to provide the crisis response service. State staff funding may include both general and federal funding. Contract providers would be strictly state general funds.

Number 27: Assessments. Clinical assessments would be done by DHW staff with the new general funds. Personnel costs may include some federal funding where the assessment services are Medicaid reimbursable.

Number 28: Outpatient Services. Services provided on an outpatient basis are Medicaid reimbursable to eligible children. For children who are not eligible for Medicaid, the services would be paid out of state general funds.

Number 29: Case Management. Both current state staff and contractors can be utilized to provide this service. State staff could be provided through a combination of both federal and state funds. Contract positions are general funds. This service is Medicaid billable, therefore it may be provided by both state staff and private providers billing Medicaid.

Number 30: Day Treatment. State general funds would be used to contract with the school districts for this service. This is not a Medicaid reimbursable service.

Number 31: Therapeutic Foster Care. This service may be provided with a combination of both federal funding sources and state general funds. DHW can access both federal IV-E and Social Services Block Grant money to provide this service where the child is eligible. DJC is limited to state funds or a portion of the Social Services Block Grant.

Number 32: Family Support. DHW uses federal Emergency Assistance (EA) funding, federal TANF money, and state general funds to provide family supports. These federal funding sources are utilized to provide general family supports and generally are not

specific to mental health needs. These federal funds may be used to pay for a family's heating bill or rent, or to repair the family vehicle, and can be used for a limited time for such services as respite. The Governor has recommended funding the Community Resource Worker program at $6 million in state general funds when the federal resource was no longer able to fund this program. While it is estimated that 9% of these non-clinical workers' time (caseloads) will include children with SED, the individual worker will not be providing clinical services themselves. Increases in family support services would come from additional general funds. While EA and TANF funding can be used for limited mental health supports, they are primarily used for non-mental health services or supports to the family.

Number 33: Respite Care. Respite care is not Medicaid reimbursable, therefore this service is provided by general funds.

Number 34: Early Identification. Expansion of the early identification of young children would be through additional state general funds.

Number 35: Transition Services. There are federal resources for Independent Living programs for children in foster care. Children not in foster care needing transitional services would primarily be funded by state general funds, unless the particular service is covered by Medicaid.

Number 36: Inpatient Psychiatric Hospitals. There has been a change in the state Medicaid rules which now allows for Medicaid reimbursement of these services where the child is eligible, otherwise this would also be state general funds.

Number 37: Residential Treatment. This service may be provided with a combination of both federal funding sources and state general funds. DHW can access both federal IV-E and Social Services Block Grant money to provide this service. DJC is limited to state funds or a portion of the Social Services Block Grant.

Number 38: State Hospital South. The state hospital is Medicaid reimbursable when the child is eligible.

Number 39: Child Expertise Professional Work Group. Funding for this recommendation would come from state general funds.

Number 40: Child Psychiatric Committee. The funding for this recommendation is state general funds.

Number 41: Parent Run Services and Supports. This recommendation would require additional state general funds.

Recommendation 25.

From among the service options contained in the Revised Idaho Service Model, Idaho systems should focus on the solid establishment of capacity within six basic

services, some of which already exist in some or all regions, including*: crisis stabilization and response services; assessment and evaluation; outpatient therapies; care management; day programming;* and *therapeutic foster care*. Additionally, *family support services* must be developed collaboratively as an adjunct to the six basic services, enabling more children to remain in their own family homes and/or in family foster homes, whenever possible. (Priority 1)

Background/Framework for Implementation
Services are not equally available in all areas. The six core services are not available to serve the total regional populations of children with SED. Service definitions are not consistently measured across the state, making tracking and sizing capacity difficult. Service definitions based on national research are currently being considered within DHW to ensure consistency in tracking methods and measurements as well as overall accountability. Once the definitions have been adopted, collection of baseline information will begin, with an annual report being submitted to the ICCMH.

The specifics of this recommendation related to each of the core services are addressed under recommendations 26-41 below.

Priority Action Items and Timelines

A By July 1, 2001, DHW will recommend service definitions, for adoption by the ICCMH, o be used to measure and track the current services in order to develop a baseline which will be used to determine sizing needs, appropriate outcomes and targets.

B New funding for DHW would be allocated to the regions based on a poverty youth population formula in order to better reflect size and resource differences among the regions. This funding will be used to develop and expand core services, including family support services in all regions consistent with the allocation formula.

Desired Result
Through implementation of the Needs Assessment recommendations related to core services, children with SED and their families will have increased access to mental health services. Core services will be established in each region, quality of services will be evaluated, and outcomes will be defined and measured.

<u>Recommendation 26.</u>
IDHW should lead regionally-based efforts to bring together FACS clinical expertise, private provider clinical expertise, law enforcement staff, court probation staff, school administrators, emergency room/acute care medical expertise, and psychiatric inpatient facilities to develop integrated crisis response protocols in each region. (Priority 1)

Background/Framework for Implementation
Crisis services will be established according to statewide protocol in each region to assist the child and family in resolving the crisis situation and to avoid hospitalization where

possible. "The underlying goals of most crisis programs are immediately, to provide brief and intensive treatment, to assist in problem solving and goal setting, to involve families in the treatment process and to assist in the development of a network of community resources for the child and family." (Stroul & Friedman, 1986) Currently in Idaho, several different models of crisis response are used. The task force will establish minimum statewide standards that utilize best practice standards.

Priority Action Items and Timelines

A By July 1, 2001, the ICCMH will appoint a task force, which includes the groups identified in the recommendation and family representatives to develop and oversee implementation of minimum standards for a local crisis response protocol. The task force will consider the most effective method of initial crisis assessment. At a minimum, there will be a local or statewide (800) telephone number with an individual who is qualified to assess the situation and connect callers to the appropriate crisis response personnel. The task force will also assess the current status of children's mental health crisis response to determine what is currently in place as a baseline for developing the protocol.

B By January 1, 2002, the standards will be developed and will include training specifications based on the minimum standards and best practice for all persons/agencies identified to respond according to the regionally adopted protocol.

C By May 1, 2002, each region will have used the minimum standards to develop and implement a regional crisis response protocol and will provide a copy of the protocol to the local councils in their region.

D Implementation and adherence to regional protocols will be monitored by the ICCMH as part of their overall monitoring plan.

Desired Result

Crisis response protocols meeting minimum standards are implemented statewide.

Recommendation 27.

The system capability to conduct clinically-based assessments and evaluations must be significantly strengthened. (Priority 2)

Background/Framework for Implementation

Assessments conducted by DHW typically fall into two categories; crisis and service assessments. Crisis Assessments occur when a child may be in immediate danger and may be conducted without informed consent of the parent or legal guardian. Service assessments are conducted by DHW for children when their parents complete an Application for Services. Service assessments require informed consent of the parents or legal guardians.

The Governor's FY 2002 budget request includes 14 additional DHW staff to provide clinically-based assessments for children seeking publicly funded mental health services.

This will significantly increase DHW's capacity to provide this service. While DHW plans to provide this service at no charge to the participating agencies at this time, tracking of referrals by agency/entity and monitoring of staffing levels to meet the demands of the referrals may require future exploration of the necessity to contract for these services.

Priority Action Items and Timelines

A By September 1, 2001, DHW will have consistent, statewide written procedures for informing families who request DHW children's mental health services of their options, rights, and responsibilities. This includes notifying parents of their right to complete an Application for Services and offering parents a face to face appointment with a professional staff member. At the time of application, the parents will be informed verbally and in writing of all of the eligibility requirements and of the right to and the process for, appeal if services are denied. Parents will also be informed of the availability of family advocacy resources. Parental notification will be documented by the parents' signature on a form acknowledging receipt of this information. A family who declines an application or services will be asked to acknowledge what they were offered and their decision not to apply for or accept services. The Plaintiffs' counsel will be notified of all denials of services.

B DHW develop an information brochure on how financial eligibility is determined and includes a sliding fee scale from the Rules Governing Family and Children's Services. The developed brochure will be reviewed in collaboration with plaintiffs' counsel and family representatives.

C By November 1, 2001, DHW will use methods of informal dispute resolution in conjunction with, or in addition to, the Department's appeals process.

D Beginning immediately with the use of current staff, DHW will use the Child and Adolescent Functional Assessment Scale (CAFAS) consistently statewide for all children whose parents apply for mental health services through DHW and those referred by the court or other agencies. The CAFAS will be conducted by a clinician (masters level or above) and will form the basis for a comprehensive assessment which is used to create the child's task/services/treatment plan if the child is determined to be eligible for services. New funding for additional staff will be used to expand the provision of this service. DHW will begin immediately to track demographic and referral information and CAFAS scores for all children assessed for services. With additional staff DHW will conduct assessments in a variety of non-clinic environments.

E By July 1, 2001, DJC will provide a written standard protocol created by its clinical staff or consultants that will assist in assessing and provide a standardized basis for tracking of children with SED. DJC will have a standardized regional evaluation/assessment at each of its three locations in the state. DJC will not necessarily use the same assessments as DHW or SDE because it must evaluate youth for different and additional purposes than DHW and SDE. All youth admitted to DJC

now go through a standard assessment and, when indicated, a clinical assessment is also made.

F DJC is also adding clinical staff as described in Recommendation 47. This will increase DJC's ability to provide clinical services to youth in its custody.

G By September 1, 2001, DHW will convene representatives from DJC, SDE, other interested community partners, and families to identify the components necessary for a multi-system assessment and plan for children accessing services through the local councils. The assessment and plan will address the child's needs across agencies. DHW will work with state and local agencies/entities to develop a quality assessment using the most appropriate tools for each referral.

H Tracking referrals will provide information regarding needed staffing levels and referral sources. This information will be used to continuously modify the provision of services appropriately.

I By September 1, 2001, DHW will develop a pre-screening tool that can be used to identify children who may need further mental health evaluation.

J By November 1, 2001, DHW will notify counties, childcare providers, agency and Headstart staff, and schools about how to access training and technical assistance on the use of the pre-screening tool. This training will also be available for inclusion in the Police Officer Standards and Training (POST) academy through an existing contract.

Desired Result
Consistent assessments will increase the ability to track and serve children with SED across agencies.

Recommendation 28.
IDHW must assure that all outpatient service definitions include the capability to provide those services in non-clinic environments, most notably in homes and in schools, and that payment/reimbursement structures include incentives for providers to deliver these services in community based and non-clinic-based locations. (Priority 1)

Background/Framework for Implementation
Current service definitions already include the ability to provide outpatient services in non-clinic environments such as homes and schools. These services are currently available at some level in all regions. The action items below will define strategies for encouraging providers to deliver these services in these settings. In addition, Medicaid is currently exploring financial incentives for private providers in rural communities. As noted in recommendation 18 the use of Psychosocial Rehabilitation Services has increased in DHW and SDE since these Needs Assessment recommendations were made.

Priority Action Items and Timelines

A Medicaid currently has a workgroup looking at financial incentives for providers to provide services in non-clinical settings, which may result in recommendations on this issue. After considering the results of the Medicaid recommendations for financial incentives, DHW may convene a workgroup which includes DJC, SDE, parent advocacy organizations, private providers, Medicaid and school districts to address barriers and incentives for private contractors to provide services in rural areas. This workgroup would only be established if there were no recommendations made by the Medicaid workgroup. If the DHW workgroup is established, the recommendations from the "School as Community Base" workgroup will also be considered in developing appropriate strategies. Specific barriers that will be addressed include costs, transportation issues, lack of providers and geographic obstacles.

B As addressed in recommendation 18, mileage reimbursement issues are being explored as a possible incentive for the provision of these services.

C By January 2002, DHW will determine the feasibility of using a traveling clinician to provide services to rural areas in each region and the feasibility of having masters level clinicians available in communities based on the CRW model. This could be a contracted or staff position. The action items under recommendation 17 addressing the expanded use of videoconferencing support this recommendation, as videoconferencing may further expand providers' ability to serve children in home and school settings.

D Continued expansion of the use of the Rehabilitation Option and the related action items under recommendation 18 also support this recommendation.

E County juvenile probation and DJC will also be able to call upon these resources.

Desired Result

Service definitions allow services to be provided in non-clinic settings. Strategies are developed addressing incentives and a payment/reimbursement structure for provision of these services, where allowed by state and federal law.

Recommendation 29.

Care management (also known as "case management") should be expanded and employed as a methodology to help families and the system manage services for those children and families with the most complex, severe, and/or complicated service needs. (Priority 2)

Background/Framework for Implementation

DHW currently provides case management services to children and adolescents who are receiving services through DHW children's mental health. Case management services may be provided by DHW or contract staff.

In addition, children who are determined to be Medicaid eligible, and are determined to have SED, can access case management services through Early and Periodic Screening, Diagnosis and Treatment (EPSDT). All case managers provided through EPSDT are trained, certified and reimbursed through Medicaid. Information on EPSDT will be included in the common publication referenced in recommendation 1.

A benefit of Utilization Management is that some current case management activities, such as pre-authorization, service review, training providers and auditing cases will be the responsibility of Utilization Management staff. This should allow DHW case management staff to focus on the essential components of case management such as linking and coordinating services for the child and family as well as providing information on the UM process and decision making.

Two of the demonstration sites are seeking to contract for case management services for the cases that they will review. This demonstrates the ability of the local councils to potentially contract for these services where they believe it is most appropriate.

Priority Action Items and Timelines

A By August 1, 2001, DHW will determine the feasibility of reimbursing case management through Medicaid.

B By January 1, 2002, DHW will conduct a cost/benefit analysis of DHW clinicians functioning as case managers.

C By January 1, 2002, DHW, with family representatives, will complete a study of case management methods and models to develop consistent standards throughout the state. The standards will include caseload standards, case manager qualifications, and intensity level standards based on best practice.

D Local councils will be made aware of the efficacy of case management. Local councils will be directed to inform families being served by the council that case management is available.

E Families will be encouraged to assist in the tasks and functions of the case manager with regard to their child's plan.

F DHW will provide on-going training opportunities and technical support to case managers providing children's mental health services.

G DHW will provide training on the use and access of the EPSDT for children with SED.

H DJC juvenile service coordinators (similar to DHW case managers) will offer, and facilitate, parents of youth in its custody the opportunity to be included in discussions of transition plans to return youth to the community and in other DJC placement and treatment decisions.

I DJC has also requested five additional juvenile service coordinators as described in recommendation 47. This will increase DJC's ability to assist both DJC youth and their families.

Desired Result
Case management caseload standards and qualifications are consistently defined and applied. Tracking will provide data to support requests for further staff where needed in the future to meet the standards established. Case management is also available through local councils, DHW, DJC, and SDE.

Recommendation 30.
Statewide and regional emphasis should include development and/or expansion of capacity in day programming. (Priority 2)

Background/Framework for Implementation
There are several methods of providing day treatment throughout the state. Some are incorporated into the child's school setting and provide tracker services and therapeutic services when needed. There are also separately identified day treatment programs inside the schools as well as separate stand-alone programs in other locations. Both DHW and local school districts provide funding for these existing models. The varying methods allow for day treatment to be developed throughout the state according to the differing resources and needs of each community.

There is currently day treatment available to some extent in each region, but it is restricted by limited resources. While there are different models in existence, most models are aimed at the 9 to 17 year old population with no specialization for age appropriateness at this point. The expansion of current models of day treatment will be the initial focus to bolster the availability of day treatment programs throughout the regions. Age appropriate models will be explored in the future. The day treatment program should recognize there are developmental differences among age groups.

Priority Action Items and Timelines
A By July 1, 2002, DHW and SDE, with input from other community agencies and families, will develop minimum standards for day treatment programs for each age level. DHW and SDE will research and review models of age appropriate day treatment and will use the information to establish standards for these.

B Annually, local councils will review each region's day treatment programs to identify gaps and make recommendations for service enhancements to the ICCMH.

C Information on outcomes, composition, gaps in day treatment service capacity utilizing the Needs Assessment model as a starting point, and compliance with established day treatment standards would be included in the ICCMH Community Report Card.

D This information would be used by DHW, DJC, and SDE to develop a decision unit and recommendations for expansion of age appropriate day treatment capacity.

E See also action items in recommendation 6.

Desired Result
Minimum standards are in effect for day treatment programs, with the identification of current capacity and future expansion targets. Age appropriate day treatment programs will be developed in all regions.

Recommendation 31.
Therapeutic foster care (TFC) should be developed systemically through close collaboration between child protection, child mental health, and juvenile justice system resources. (Priority 2)

Background/Framework for Implementation
Research confirms that therapeutic foster care produces better outcomes and is less costly than more restrictive care. Development of therapeutic foster care is and will be a priority for the Department of Health and Welfare. DHW and the regions will make concerted efforts to recruit and retain families to work with children with SED**.**

In order to increase recruitment and retention, several issues must be addressed. These include clinical support, training, quality assurance mechanisms, reimbursement issues, and staff support to regions and within regions. These issues are similar for recruitment and retention of respite care providers and are addressed in recommendation 33.

The Governor's FY2002 budget proposal includes a 10% increase in reimbursement rates for all foster care.

Priority Action Items and Timelines
A By March 1, 2002, DHW will develop and implement a plan for providing on-going training and clinical support services for all therapeutic foster families serving children with SED through DHW. Training will include methods to facilitate on-going family involvement with the therapeutic foster family during the child's placement.

B By March 1, 2002, and as an on-going activity, DHW, with the local councils and local businesses, will explore ways to create community incentives for therapeutic foster families. Community incentives may include such things as vouchers and discounts at local businesses.

C By February 1, 2002, DHW will identify barriers that may hinder a family's access or use of therapeutic foster care or respite, such as prohibitive costs to the family and the obstacles that may hinder on-going family involvement. Costs to families for out-of-home care will be consistently determined according to the child support guidelines in DHW's rules or DJC's statute.

D By February 1, 2002, DHW will determine the feasibility of using this service as a possible respite alternative and the barriers that may be in place around that use.

E Information regarding outcomes and gaps for service capacity will be included in the ICCMH report to the Governor and the Idaho State Planning Council on Mental Health.

F DJC will take advantage of contracts for available therapeutic foster care, when appropriate, by releasing youth in its custody to appropriate therapeutic foster care treatment when the youth and the community could best be served by such a placement.

G DJC will consult with DHW concerning development of therapeutic foster care for juvenile offenders with SED and concerning training of therapeutic foster care parents.

H Families will be advised of their and the Department's rights and responsibilities and potential benefits of this service.

I By March 1, 2002, DHW will develop and implement strategies to increase the number of therapeutic foster homes that will include support, retention, recruitment, and reimbursement rates of all families. This will include a study of other state's reimbursement rates.

J DHW, in consultation with DJC and families, will explore alternative ways of determining a family's financial obligations for a child in out-of-home care. This will include exploring a possible rule change.

Desired Result
Therapeutic foster families serving children with SED are trained and supported. Therapeutic foster homes are developed and funded to address identified needs and expand services or alternatives to Therapeutic Foster care will be identified. Recruitment and retention of these families are enhanced through both state and community level incentives.

Recommendation 32.
A model like the one that established the Family Resources Partnership Program should be used to expand regional- and county-based family supports, including small amounts of flexible funds and a group of trained workers to assist with other support needs. (Priority 1)

Background/Framework for Implementation
The Family Resources Partnership Program (commonly referred to as the Community Resource Worker Program) is a successful program for providing community based support to families in need. This program was funded through a federal funding source

that is no longer available; therefore, the Governor has requested general funding to continue this program. It is estimated that nine percent of the total children served in the in the Community Resource program have mental health issues and can benefit from this program's non-clinical services and referrals. Funding of this school-based program would ensure continuation of these services to children with SED in schools.

DHW currently has emergency assistance funding available to help eligible families for a period of 120 days in any 12-month period. Eligible families include families of children with SED. Emergency Assistance funds may be used for a variety of needs such as payment of rent, utilities, appliances and transportation. These are programs designed to support families, but not necessarily those that have children with SED. Many of the supports discussed in the recommendation, such as respite care (33), family-to-family support (41) and transportation to services (s 17,18, and 28) are addressed under other recommendations.

For children who are dually diagnosed with DD and MH, limited family supports may also be accessed through the Developmental Disabilities Program.

Priority Action Items and Timelines

A DHW will work with SDE to ensure that eligible families continue to have access to emergency assistance funding through the Community Resource Worker Program.

B DHW will develop a workgroup with DJC, SDE, and parents to identify family supports and make recommendations as to a decision unit for those services.

C Local councils will assist in identifying what supports are needed in their area and defining priorities and funding for these supports.

D Training provided by parents (recommendations 1 and 41) will assist workers in understanding and identifying needed supports for families.

E DHW will explore the use of community resources, including students in higher education programs in related fields, to provide family supports. The authors of the Needs Assessment pointed out that the provision of these types of services may be provided by lay people or paraprofessionals.

Desired Result

Small amounts of flexible funding are available to families for family supports. Trained workers are available for family support services. Family supports are developed according to community needs.

<u>Recommendation 33.</u>

Respite capacity must be developed in Idaho – families across the state stated that it was one of their top priority needs for maintaining their children at home. (Priority 1)

Background/Framework for Implementation
Respite care is a temporary child care service that may occur in two settings: as a planned respite or respite provided in a crisis situation. Respite may be provided in the child's home or in another appropriate setting. Respite care providers can be identified by the family or agencies serving the family.

The issues and strategies related to recruitment and retention of respite care providers are similar to those identified in recommendation 31 regarding therapeutic foster care.

Priority Action Items and Timelines

A By December 1, 2001, DHW will develop statewide policies and standards related to authorization, access and reimbursement for respite care.

B By May 1, 2002, DHW will identify areas of the state where gaps in respite care capacity exist and develop strategies for recruitment and retention to increase capacity.

C DHW, in collaboration with families, will train respite care providers regarding appropriate strategies for working with children with SED on an on-going basis.

D See also recommendation 31, regarding Therapeutic Foster Care services.

E On an on-going basis, DHW will develop strategies for identifying existing potential respite resources within the child's existing support system and community, such as extended family, neighbors and friends who might be willing to provide limited respite care when provided with appropriate training and sufficient supports.

Desired Result
Respite care providers serving children with SED are trained and supported. Additional respite care providers are developed to serve families who have children with SED.

<u>Recommendation 34.</u>
The Cabinet Council should lead an effort to expand services aimed at early identification and treatment for the needs among younger children before those needs escalate to the level of "severe" disturbances. (Priority 2)

Background/Framework for Implementation
As the authors of the Needs Assessment noted, there is no consensus nationally on how to classify emotional disturbances for children younger than nine. At these younger ages, children are most likely to be identified as having behavior problems such as prolonged crying, often not paying attention, hurting other children or showing excessive anger. If these social, developmental, and emotional delays can be addressed early on, some children may avoid more severe disturbances. Even for those children who may develop

more severe disturbances, early identification will enable parents and care givers to manage their child's illness more effectively.

Some school districts currently screen or test pre-schoolers and have special preschools to help children make gains in areas of delayed development. Most Head Start programs also contract with consulting clinicians who conduct assessments and work with families to develop individualized programming for children with special needs.

Priority Action Items and Timelines

A By May 1, 2002, the ICCMH will establish an early identification workgroup consisting of child care providers, pediatricians, infant toddler staff and a council member, school districts, parent advocacy, Head Start, and local council members to identify an age appropriate assessment tool and develop assessment methods that can aid in the accurate identification of young children with developing SED symptoms. In addition, this workgroup should identify appropriate treatment methods and additional programming options for this age group.

B By December 1, 2002, DHW will conduct outreach and offer training to community resource workers, child care providers, pediatricians and other health care providers throughout the state on the use of the tool to identify children who may need further mental health evaluation, a referral process for accessing DHW children's mental health services, and community treatment options for this age group. The early identification workgroup should identify additional groups to be trained by DHW who may benefit from this training.

C Outreach activities will include families with young children and provide information about Child Find, warning signs, and early intervention.

D By February 1, 2002, DHW and SDE will clarify the potential for identifying children with SED within the existing Child Find efforts.

E The Bonneville County local council is currently being used as a demonstration site to develop a model of identification and treatment of this population to expand this service.

F Once appropriate treatment methods and programming options have been identified, recommendations will be developed and provided to the ICCMH.

Desired Result

Families and community members who provide care for children younger than nine have access to, and are provided information about, education and training opportunities to help them recognize developmental issues that may be indicators of emotional disturbance. Appropriate treatment services and methods are provided to younger children before those needs escalate to the level of "severe" disturbances.

Recommendation 35.

The Cabinet Council should lead an effort to address transition needs of adolescents with serious emotional disturbances as they age out of child-serving systems and potentially into adult service systems. (Priority 2)

Background/Framework for Implementation

The Children's Mental Health Services Act provides services on a voluntary basis until age 18. At age 18 several factors affect the family and individual's ability to access continued services through DHW, and DJC. Legal consent changes from the parent to the individual; clinical eligibility is more restrictive for adult services than for children's services; and eligibility for Medicaid may not extend beyond the 18th birthday. These factors create the need for a planned transition for the child and family to identify mental health resources available to the individual as they begin to transition out of the child serving system.

Changes to the DHW statute and rules have been developed, and are now awaiting legislative approval, which would allow children to remain in foster care or other programs providing educational or other services past their eighteenth birthday. Options are currently being explored by DHW for continuing the child's Medicaid eligibility to the age of 21 where they are continuing in a program or service that was previously covered.

DJC has authority to retain custody until age 21. DJC has existing protocols for the transition and release of youth in its custody at time of release. DJC will coordinate with DHW to take advantage of any programs that DHW or the counties may offer.

School districts throughout Idaho are responsible for providing educational and related services to IDEA eligible students, including those identified as having emotional disturbances, until they meet the local district graduation requirements or the age 21, whichever comes first. In addition, school districts have the ability to begin transition planning for all secondary age students, starting with a course of study at age 14, and full transition service planning beginning at age 16.

Priority Action Items and Timelines

A By March 1, 2002, the ICCMH will develop minimum standards and best practice protocols for transitioning youth.

B By June 1, 2002, local councils will develop local protocols for serving youth transitioning out of the council's services. Local protocols will be modeled after the ICCMH standards.

C By July 1, 2001, DHW will require that all children age 16 and older who are receiving DHW children's mental health services, have a transition plan developed, and when appropriate in collaboration with the local school districts, that addresses the child's mental health needs and individual circumstances.

D School districts will continue to provide transition planning when appropriate in collaboration with DHW as part of the Individualized Education Program (IEP) for eligible students who have emotional disturbances.

Desired Result
All children aging out of the children's mental health system have a transition plan to address their mental health needs.

Recommendation 36.
No additional inpatient psychiatric beds for children or adolescents are recommended at this time. (Priority N/A)

Background/Framework for Implementation
At this time, DHW is not requesting any additional psychiatric beds for children with SED. Inpatient hospitalization is the most restrictive and expensive type of care for children and adolescents with SED. While some children with severe disorders do require a highly restrictive treatment environment, the defendants agree with the authors of the Needs Assessment that no additional beds are needed at this time and that new funding should be used to build less restrictive forms of treatment.

However, DJC, which is now a defendant, must acquire new beds as necessary in the state to meet the needs of its population, and this is part of the Governor's budget. We need to qualify this sentence by saying that the Defendants agree with the authors of the Needs Assessment that no additional beds are needed for DHW at this time and that new DHW funding should be used to provide less restrictive forms of treatment.

Priority Action Items and Timelines
A DHW will continue to monitor its utilization of and gaps in the service capacity of psychiatric beds for children with SED and will report this information to ICCMH annually.

Desired Result
No increase in psychiatric beds is recommended at this time, consistent with the recommendation of the Needs Assessment authors. DHW will continue to monitor the use of this service for any needed future modification.

Recommendation 37.
No additional residential treatment center beds for children or adolescents are recommended at this time. (Priority N/A)

Background/Framework for Implementation
At this time, DHW is not requesting any additional residential treatment center beds for children with SED. "Residential treatment centers are the second most restrictive form of care (next to inpatient hospitalization) for children with severe mental disorders. However, local councils may, within existing funding, choose to develop short-term

community based residential resources. Additionally, because this service is not Medicaid reimbursable, this is one of the most expensive forms of care and any expansion of this service at this time would divert resources away from the development of less restrictive treatment forms. Where appropriate, this form of care will be used for children with SED.

Until the number of juveniles with SED committed to DJC custody is slowed or reduced, DJC must continue to respond to the needs of youths committed to its custody and will add residential treatment beds as necessary.

Priority Action Items and Timelines

A DHW will continue to monitor its utilization of and gaps in the service capacity of residential treatment beds for children with SED and will report this information to the ICCMH annually.

Desired Result

No increase in residential treatment beds is recommended at this time, consistent with the recommendation of the Needs Assessment authors. DHW will continue to monitor the use of this service for any needed future modification.

Recommendation 38.

No immediate changes in the purpose or functioning of the State Hospital South adolescent program are recommended at this time. (Priority 2)

Background/Framework for Implementation

At this time, DHW is not requesting any changes in the purpose or functioning of the State Hospital South (SHS) adolescent program.

Priority Action Items and Timelines

A DHW will continue to monitor its utilization of State Hospital South adolescent unit for children with SED and will report this information to the ICCMH annually.

B Staff at SHS will be fully informed of the implementation of this plan and any necessary changes for purposes of discharge planning.

Desired Result

No change in State Hospital South is needed or recommended at this time, consistent with the recommendation of the Needs Assessment authors. DHW will continue to monitor the use of this service for any needed future modification.

Recommendation 39.

The Director of the IDHW should establish a time-limited Child Expertise Professional Development work group to study shortages in expertise and make recommendations for the development of suitable training resources within Idaho. (Priority 2)

Background/Framework for Implementation

Idaho has a limited number of professionals with specific child treatment expertise. With the limited resources, it is important to use these professionals in the most effective manner possible and to explore professional development options for increasing the expertise that is available.

Idaho State University has just awarded Idaho's first Ph.D. in Clinical Psychology. This program, which began in 1995, was developed to serve and respond to underserved populations. The University of Idaho offers masters and doctoral programs in the areas of counseling and school psychology as well as specialized training in rehabilitation/community agency counseling. Boise State University offers a masters of social work program. Public agencies serving children with SED need to work closely with these institutions to design program elements that address public sector children's issues and encourage students to consider public sector service.

Currently DHW has a contract with Eastern Washington University to provide stipends to students who are accepted into the University's Master of Social Work program and who sign an agreement to work for DHW's Family and Children's Services program upon graduation. Several of the graduates from this program are employed by DHW as clinicians, supervisors and community resource workers.

In addition, DHW's Children's Mental Health program, SDE and Vocational Rehabilitation are represented on the University of Idaho's Counseling and School Psychology Advisory Council. This council brings together university faculty, public sector agencies, and community members to review the University's curriculum as it prepares students for public service.

The Idaho Department of Human Resources and individual agencies are also currently working to increase expertise in these areas through recruitment and training. DHW has two full time human resources staff who specialize in recruitment and retention for identified hard-to-fill positions, including clinicians. These staff work with all the Idaho universities as well as with out-of-state resources.

Priority Action Items and Timelines

A By September 1, 2001, DHW will establish a workgroup bringing expertise from DD, education, DJC, CMH, families and state Human Resources to examine existing recruitment, training, and retention efforts across systems. The workgroup will include Eastern Washington and all Idaho universities and will focus on building on existing resources and identification of existing training and gaps in service. The workgroup should also explore the use of technology (i.e., the Idaho CareLine and web pages) for disseminating information about educational, employment and training opportunities and resources. The workgroup will produce an action plan with timelines for consideration by the ICCMH by April 2002. The action plan will address shortages in availability and access to child mental health professionals.

Desired Result
Professional development opportunities and resources specific to increasing expertise in children's mental health are identified.

Recommendation 40.
IDHW, especially including the Medicaid division and in partnership with other relevant entities, should establish a Child Psychiatric Advisory Committee to explore and recommend improvements in psychiatric services within the child-serving systems. (Priority 2)

Background/Framework for Implementation
Limited psychiatric coverage is available in each region. Although these services could be improved, the Needs Assessment did not identify this recommendation as the highest priority.

Medicaid currently addresses barriers to recruitment and retention of service providers through Quality Improvement Teams. These teams may benefit from input of child psychiatrists since barriers and strategies for recruiting this group of professionals may be different from those for other groups.

Priority Action Items and Timelines

A By July 1, 2001, DHW will add child psychiatrists to the Medicaid Quality Improvement Team or will determine the best way to get input from child psychiatrists regarding the barriers of recruitment and retention, especially in rural areas and their ideas for addressing shortages in manpower and expertise.

B By October 1, 2001, DHW will develop a preliminary plan for increasing psychiatric services in the state including rural areas by utilizing the findings of the Medicaid Quality Improvement Team.

C See also recommendation 17, which addresses expanding the use of videoconferencing as a possible method to enhance utilization of psychiatric services.

D See also recommendation 18, which addresses the expanded use of the Rehabilitation Option, and recommendation 28, which addresses the provision of services in a non-clinic setting.

Desired Result
Increased availability of psychiatric services to children with SED in all regions.

Recommendation 41.
IDHW should initiate discussions with parents and parent group representatives to explore areas in which parent-run services or supports might be established within community systems. (Priority 2)

Background/Framework for Implementation

Research shows that parent run services and supports are generally well received and create positive change for participating families. Participation in self-help groups has been shown to meet parents' support needs, increase self-esteem and coping skills, and reduce feelings of stress, isolation, guilt and anger. Further, parents who participate in these services increase not only their knowledge of mental health service delivery but also their self-efficacy in dealing with the service delivery system. (Kutash and Rivera, 1996) Parent support also results in family coping and leads to a decrease in symptoms for children.

DHW currently contracts with the Idaho Federation of Families to provide support, education, information and a statewide organization to represent families of children with SED. Through this contract the Federation of Families will establish at least two satellite offices by December of 2001.

Other advocacy organizations serving populations broader than families of children with SED may also have the capacity to provide these services.

Priority Action Items and Timelines

A Local councils will be encouraged to work with parent representatives to develop parent to parent supports and services in the local area.

B By December 1, 2001, DHW and DJC will identify potential ongoing funding that can be used to reimburse parent run training or services.

C The number of parent run support services will be tracked by the local councils and will be reported to the ICCMH annually.

D During 2001, DHW will work with the Idaho Federation of Families and other parent organizations to identify types of services and supports that could be provided by families and the types of supports and incentives that could be used to tap this resource.

E By September 1, 2001, and annually thereafter, DHW, SDE, County Probation, School Districts and DJC will identify methods for including parents in training opportunities for staff and agencies.

F DHW and DJC will seek funding to continue to contract with a parent advocacy organization for the family participation survey.

G The Federation of Families will report to DHW, DJC, SDE and the State Planning Council on Mental Health regarding supports and services available and provided to families.

H See also, recommendations 1 and 32.

Desired Result

Active parent organizations provide advocacy, training and support for families throughout the state.